STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445501	A. BUILDING 01 - MAIN B. WING _____	12/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST HILLS HEALTH AND REHAB	6801 MIDDLEBROOK PIKE KNOXVILLE, TN 37919

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and testing, the facility failed to have corridor doors capable of resisting the passage of smoke. The findings include: Based on observation and testing on December 9, 2013 at 11:20 a.m. revealed the dining room entrance door on the right, would not close within its frame enough to resist the passage of smoke. When the door was closed, the top of the door was warped and would not close within the door frame to form a smoke resistant barrier. This finding was verified by the maintenance director and acknowledged by the administrator	K 017	**K 017** 1. No residents were identified as having been affected. A new entrance door to the dining room has been ordered by manager of Carolina Doors on 12/20/13. 2. The Maintenance Director and maintenance assistants assessed all fire doors for proper closing to seal off the passage of smoke in all areas on 12/9/13. No other doors were affected. 3. The maintenance assistants were in-serviced by the Maintenance Director 12/23/13 on proper closing and sealing of the fire doors. 4. The Maintenance Director will audit all fire doors monthly to ensure proper closing and sealing of fire doors and ongoing during monthly preventative maintenance rounds. Results of findings will be reviewed by the Administrator or Maintenance Director in the Quality Assurance Performance Improvement Committee for 3 months and/or until one hundred percent compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department.	1/13/14

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	12/31/13

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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WEST HILLS HEALTH AND REHAB	6801 MIDDLEBROOK PIKE KNOXVILLE, TN 37919

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K 017	Continued From page 1 during the exit conference on December 9, 2013.			
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to have self-closing doors to hazardous areas. The findings include: Observation on December 9, 2013 between 6:00 a.m. and 11:30 a.m. revealed the following rooms were greater than 50 square feet and were being used for storage of combustibles. These storage room doors were not self-closing: 1. Room 822 2. Room 706 3. Room 708 4. Room 710 5. Room 711 6. Room 712 7. Room 714 8. Room 715	K 029	**K 029** 1. No residents were identified as having been affected. Door closures were placed on rooms 822, 706, 708, 710, 711, 712, 714, and 715 by 12/20/13 by the maintenance staff. 2. The Maintenance Director and maintenance assistants assessed the rooms used for storage greater than 50 square feet for door closures on 12/20/13. No other rooms were affected. 3. The maintenance assistants were in-serviced by the Maintenance Director 12/23/13 on rooms used for storage greater than 50 square feet must have a door closure. 4. The Maintenance Director will audit all non-patient rooms to ensure storage rooms greater than 50 square feet have door closures monthly and ongoing during preventative maintenance rounds. Results of findings will be reviewed by the Administrator or Maintenance Director in the Quality Assurance Performance Improvement Committee for 3 months and/or until one hundred percent compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department.	1/13/14

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K 029	Continued From page 2 These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on December 9, 2013.			
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to have exit and directional signs installed at required exits. The findings include: Observation on December 9, 2013 at 7:40 a.m. revealed the interior courtyard has 5 doors leading back into the build, only 2 are exits doors. The other 3 doors are locked from reentry of the facility. The 2 required exit doors are not provided with illuminated and directional exit signs that can be seen from any location of the interior courtyard. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on December 9, 2013.	K 047	K 047 1. No residents were identified as having been affected. The electrician with MaGaha has ordered the two illuminating signs for the exit doors leading back into the building from the courtyard on 12/18/13. 2. The Maintenance Director reviewed all the signs in the facility on 12/9/13. No other exit signs needing illumination were found. The electrician with MaGaha will place the illuminating signs at the doors in the courtyard by 12/30/13. 3. The maintenance assistants were in-serviced by the Maintenance Director 12/23/13 regarding the illuminating and directional exit signs must be placed and seen from any location of the interior courtyard. 4. The Maintenance Director will audit all illuminating signs monthly and ongoing to ensure the signs are illuminating during monthly preventative maintenance rounds. Results of findings will be reviewed by the Administrator or Maintenance Director in the Quality Assurance Performance Improvement Committee for 3 months and/or until one hundred percent compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department.	1/13/14
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the			

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K 056	Continued From page 3 building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to have all areas of the facility fully sprinklered. The findings include: Observation on December 9, 2013 at 7:53 a.m. revealed the elevator pits do not have sprinkler coverage. The facility elevators are hydraulic. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on December 9, 2013.	K 056	K 056 1. No residents were identified as having been affected. 2 . The facility have no other elevators that would be affected. Morristown Sprinkler will sprinkle the elevators pits by January 13, 2014. 3. The maintenance assistants were in-serviced by the Maintenance Director 12/23/13 the elevators pits must be sprinkled because the elevators are hydraulic. 4.The Maintenance Director will audit monthly to ensure the sprinklers are maintained in reliable operating condition times 3 months and ongoing during monthly preventative maintenance rounds. Results of findings will be reviewed by the Administrator or Maintenance Director in the Quality Assurance Performance Improvement Committee for 3 months and/or until one hundred percent compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and record review, the			1/13/14

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K 062	Continued From page 4 facility failed to maintain the automatic sprinkler system. The findings include: Observation and record review on December 9, 2013 between 7:00 a.m. and 11:00 a.m. revealed the following: 1. The two (2) connecting breeze ways for the nursing home and nursing home rehab have mixed matched sprinkler heads of quick response and standard response type sprinkler heads. 2. Record review revealed the 5 year obstruction investigation test is past due. 3. Record review revealed the water motor gong is inoperable. 4. Record review revealed the annual main drain test cannot be conducted due to the sprinkler riser room flooding. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on December 9, 2013.	K 062	K 062 1. No residents were identified as having been affected. The two sprinkler heads were changed by Morristown Sprinkler, the five year obstruction investigation test was completed by Morristown Sprinkler, the water motor gong is operable and the sprinkler riser room flooding was corrected by Morristown Sprinkler, all completed on 12/13/13. 2. The Maintenance Director and assistants assessed all sprinkler heads to ensure the correct sprinkler heads were in place on 12/13/13. 3. The Maintenance Director was in-serviced on 12/13/13 by the Administrator to ensure the five year obstruction tests are completed, the water motor gong is operable, all sprinkler heads match and the sprinkler rising room is not flooded. 4. The Maintenance Director will audit the water motor gong, all sprinkler heads in the facility, and the sprinkler rising room monthly and ongoing to ensure the sprinkler heads match, the water motor gong is operable, and the sprinkler riser room is not flooded during monthly preventative maintenance rounds. The Maintenance Director will ensure the five year obstruction investigation is completed when due. Morristown Sprinkler will check the sprinkler riser room, the water motor gong, and sprinkler heads quarterly on going to ensure all is functioning. All findings will be reviewed by the administrator or Maintenance Director in the Quality Assurance Performance Improvement Committee for 3 months and/or until one hundred percent compliance is achieved. Quality Assurance Com-	1/13/14
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain the heating, ventilating, and air conditioning (HVAC) in accordance with NFPA			

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		K 062	mittee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department.	
		K 067	K 067 1. No residents were identified as having been affected. The four year fire and smoke damper maintenance was started on 12/17/13 by Premier Services and will be completed by 12/31/13. 2. Premier Services will complete the fire and smoke damper maintenance on all dampers by 12/31/13. 3. The Maintenance Director was in-serviced by the Administrator on 12/13/13 the fire and smoke damper maintenance must be performed every 4 yrs. 4.The Maintenance Director will audit all dampers to ensure the fire and smoke dampers are functioning monthly and ongoing during monthly preventative maintenance rounds and Premier Services will perform maintenance on the fire and smoke dampers every four years	1/13/14

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/31/13

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K 067	Continued From page 5 90A. The findings include: Record review and interview with the maintenance director on December 9, 2013 at 7:05 a.m. revealed the facility failed to perform the 4-year fire and smoke damper maintenance. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on December 9, 2013.	K 067	ongoing. Results of findings will be reviewed by the Administrator or Maintenance Director in the Quality Assurance Performance Improvement Committee for 3 months and/or until one hundred percent compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department.	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to have the means of egress continuously maintained free of all obstructions or impediments. The findings include: Observation and interview with the maintenance director on December 9, 2013 at 11:05 a.m. revealed that over the weekend staff would store items out in the 700 wing corridor. At 6:00 a.m. on the general tour of the facility the 700 wing exit corridor was being used for storage. There were	K 072	**K 072** 1. No residents were identified as having been affected. The carts, beds, and general items were removed from the corridor by the maintenance staff on 12/13/13. 2. No other areas were identified for obstructions. All items were removed from the 700 hall leaving the hall clear. 3. All staff will be in-serviced by their department to not store anything in the hallway on the 700 hall or any other hallway which could cause an obstruction as this is an exit route. All will be in-serviced by 12/31/13. 4. The maintenance director will audit all hallways monthly and ongoing to ensure there are no items stored on any hallway during monthly preventative maintenance rounds. Results of findings will be reviewed by the Administrator or Maintenance Director in the Quality Assurance Performance Improvement Committee for 3 months and/or until one hundred percent compliance is achieved. The Quality Assurance Performance Improvement	1/13/14

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K 072	Continued From page 6 numerous carts, beds, and general items in this corridor. The 700 wing is no longer being used for patient use but it is still an exit corridor for the facility. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on December 9, 2013.	K 072	Committee consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation, the facility failed to have a remote annunciator for the emergency generator in a continuously monitored location. The findings include: Observation on December 9, 2013 at 8:30 a.m. revealed the remote annunciator is located in an area of the building that is not in a continuously monitored location. The remote annunciator is located in the attached assisted living, which is no longer providing services. The attached assisted living does not have any offices or staff areas that are occupied twenty four hours a day.	K 144	K 144 1. No residents were identified as having been affected. 2. No other areas were identified as being affected by location of annunciator alarm/panels as the other floors are in place. A baby monitor will be placed near the annunciator panel and monitored by the 2nd floor nurse 24hrs/seven days a week. Maintenance will check annunciator panel twice daily Monday through Friday and Weekend Nurse Supervisor will check annunciator panel twice daily on the weekends until floor is opened. 3. Licensed nursing staff and maintenance staff will be in-serviced by their department regarding the monitoring of the annunciator panel until the floor is opened. All will be in-serviced by 1/2/14. 4. The Maintenance Director will audit the annunciator panel twice daily Monday through Friday and Weekend Nurse Supervisor will audit the annunciator panel twice daily on the weekends until floor is opened to ensure there are no alarms sounding on the annunciator panel. After the floor opens, then the Maintenance Director will audit the annunciator panel monthly with preventive monthly maintenance	1/13/14

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K 144	Continued From page 7 This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on December 9, 2013.	K 144	rounds. Results of findings will be reviewed by the Administrator or Maintenance Director in the Quality Assurance Performance Improvement Committee for 3 months and/or until one hundred percent compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and testing, the facility failed to maintain electrical outlets. The findings include: Observation and testing on December 9, 2013 at 6:20 a.m. and 11:00 a.m. revealed the following electrical outlets in the corridor were not secured into the wall: 1. Corridor by room 508. 2. Corridor by room 514. 3. Corridor by room 213. 4. Corridor by room 608. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on December 9, 2013.	K 147	K147 1. No residents were identified as having been affected. The Maintenance Director and maintenance assistants secured the following outlets to the wall: corridor by room 508, corridor by room 514, corridor by room 213, and corridor by room 608 by 12/19/13. 2. All corridors were checked by the Maintenance Director for loose electrical outlets by 12/19/13. No other loose electrical outlets were found. 3. The Maintenance Director was in-serviced by the Administrator on 12/13/13 on ensuring the electrical outlets being secured. 4. The Maintenance Director will audit all electrical outlets every 3 months x2, then every 6 months ongoing to ensure the electrical outlets are secure in the corridors. All findings will be reviewed in the Quality Assurance Performance Improvement Committee for 3 months and/or until one hundred percent compliance is achieved. The Quality Assur-	1/13/14

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		K147	ance Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department.	